Alabama Medicaid

Additional Location Enrollment Application

Alabama Medicaid Basic Provider Enrollment Information Form

Guidelines

- The location, for which you are using the Additional Location Enrollment Application, must be a location, which will be added to the existing group number given on this application.

- Only individual providers enrolling additional locations are eligible to use this enrollment packet. Facility/Institutional and individual providers enrolling as participants in special programs, such as Children's Specialty Clinics (CRS/Sparks), Federally Qualified Health Centers (FQHC), and Rural Health Clinics (PBRHC or IRHC) are not eligible to use this enrollment packet.

- Medicare certification dates will not be used as an effective date for additional locations. Only the original location indicated on the Medicare certification letter, will be retro-activated, if the original location is registered with the Alabama Medicaid program.

- If the individual's existing provider number indicated on this form is not currently enrolled in the Plan First and/or EPSDT program, but you would like to participate in either program for this location, please call 1-888-223-3630, to request the EPSDT and/or Plan First enrollment forms. CLIA certification is required to bill services related to the EPSDT and/or Plan First program. A copy of the CLIA certificate must accompany EPSDT and/or Plan First enrollment forms.

ALABAMA MEDICAID – ADDITIONAL LOCATION ENROLLMENT APPLICATION

(1) The following information should be completed on Applicant:

Individual's Existing Provider Number:_____ **V** Group/payee Existing Provider Number: _____ **V**

Name: (Last) _____ (First) _____ (Middle) _____

Physical Address: _____ (City) _____ (State) _____ (Zip Cd +4) _____

Mailing Address:_____ (City) _____ (State) _____ (Zip Cd +4) _____

Business Phone No: (____)_____ Fax No: (____)_____ Toll Free No: (____) _____

County: _____ Individual SSN: _____ **V** Medicare No: _____ **V**

State License No_____ **V** License Issue Date: (Month) ___ (Day) ___ (Year) ___

DEA No.: _____ **V** DEA Expiration Date: _____ **V** CLIA No _____ **V**

Will you perform EPSDT screenings at this location? **Yes** ( ) **No** ( ) **V**
Will you perform Plan First services at this location? **Yes** ( ) **No** ( ) **V**

(If indicating yes to the two above questions, the provider number indicated above must already be enrolled in the programs. If not enrolled please call 1-888-223-3630 for program enrollment forms.)

(2) Has your license ever been limited, suspended or revoked in any state, or has your Medicare-Medicaid participation ever been limited, suspended or revoked? **Yes** ( ) **No** ( ) If yes, attach a full explanation.

(3) If enrolling as a Anesthesia Assistant, Nurse Practitioner, or Physician Assistant please complete the following sections regarding your employing physician:

Name: _____ Active Medicaid Provider Number: _____ **V**

(4) If you wish your payments made to someone other than yourself, (such as a professional group, hospital, or clinic) please complete the following information. This information will be used on your EOPs and tax statements. This information must be consistent with the payee information provided to Medicare, the IRS and the group/payee provider number indicated above.

Payee Name (to appear on EOPs):_____ **V** IRS Tax No: _____ **V**

Payee Address: _____ (City)_____ (State)_____ (Zip Cd +4) _____

Business Phone No: (____)_____ Fax No: (____)_____ Toll Free No: (____) _____

Contact Person:_____ Phone Number of Contact Person:_____

I understand there may be state and federal penalties and prosecution for the making of false statements on this application. I certify that to the best of my knowledge, the information supplied on this application is accurate and complete and is hereby released to EDS for the purpose of issuing an Alabama Medicaid Provider Number. By signing below I acknowledge this application is held to the same terms and conditions contained in the provider enrollment agreement signed during initial enrollment in the Alabama Medicaid Program.

_____ _____
Applicant's Signature (Must be personally handwritten) **Date**

If there are any questions concerning the completion of this application, please contact our Provider Enrollment Unit. Our Toll-Free Number is 1-888-223-3630 or 334-215-0111. Return this form to EDS, Provider Enrollment, P.O. Box 244035 Montgomery, AL 36124. Please remember to retain a copy of this document in its entirety for your records.

FOR OFFICE USE ONLY, DO NOT WRITE IN THIS AREA

	EDS ACTION
Provider Number: _____	DATE: _____ BY:_____
Group Number: _____	_____
Unique I.D. Number: _____	_____
	_____